HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND

COMMUNITY AFFAIRS

PARLIAMENTARY INQUIRY INTO SUBSTANCE ABUSE

Submission from the Australian Healthcare Association (AHA)

13 June 2000

Forward

The Australian Healthcare Association (AHA) is the peak industry association representing public and not-for-profit hospital and healthcare organisations. AHA's objective is to advocate nationally on behalf of the industry's interests and to provide a national network of information, education, advice and support for public and not-for-profit healthcare organisations.

Attached is our submission to the Parliamentary Inquiry into Substance Abuse. We have also attached for your information, a submission from one of our affiliated State Associations: The Victorian Healthcare Association (VHA).

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Aim of the AHA and VHA Submissions

The aim of these submissions is to comment on the social and economic health care costs of substance abuse.

All comments are in relation to point five of the terms of reference, *health care costs* only.

Introduction

The AHA submission comprises:

i) Statistical evidence regarding the differential health care costs of licit versus illicit drug abuse;

ii) A discussion of the phenomenon of polypharmacy and adverse medication events in hospitals; and

iii) Recommendations.

Statistical Evidence

Collins and Lapsley (1996) have found that the health care costs associated with alcohol and tobacco abuse far outweigh the health care costs associated with abuse of illicit drugs. Health care costs associated with tobacco abuse are particularly high, amounting to $832.5 million in 1992. Moreover, approximately 80 percent of the burden of these health care costs falls upon Federal and other governments. The statistical evidence is presented in detail below:

Economic costs of alcohol abuse:

Total health care costs - $145.3 million in 1992 (1996 prices);

These costs are net of premature deaths, which relieve the community of some health care cost burdens.

Incidence of social costs associated with alcohol (in 1992):

- **Costs borne by individuals - $31.2 million; and**
- **Costs borne by Federal and other governments - $114.2 million.**

<u>Economic costs of tobacco abuse:</u>

Total health care costs - $832.5 million in 1992 (1996 prices);

Incidence of social costs associated with tobacco (in 1992):

- **Costs borne by individuals - $185.9 million; and**
- **Costs borne by Federal and other governments - $646.7 million.**

<u>Economic costs of abuse of illicit drugs:</u>

Total health care costs - $42.7 million in 1992 (1996 prices);

Incidence of social costs associated with illicit drugs (in 1992):

- **Costs borne by individuals - $9.7 million; and**
- **Costs borne by Federal and other governments - $33.0 million.**

<u>Economic costs of all drug abuse:</u>

Total health care costs - $1,015.5 million in 1992 (1996 prices).

NB. The sum of the individual costs of all drugs exceeds the 'All drugs' total as a result of adjustment for the effects of aggregation of the individual aetiological fractions.

Polypharmacy and Adverse Medication Events in Hospitals

There is a growing body of literature focusing on polypharmacy, or the prescription of multiple medications. For example, Chutka, Evans, Fleming, and Mikkelson (1995) have found a direct correlation between advancing age and number of medications prescribed. Further, Nair (1999) has found that while people over the age of 65 comprise only 12 percent of the Australian population, 40 percent of all prescriptions are for this age group.

Due to the phenomenon of polypharmacy in relation to the elderly, the risk of an adverse medication event (AME) increases dramatically for people over the age of 65. For example, Walker and Wynne (1994) reported that increasing the number of medications prescribed has been shown to independently increase the risk of an adverse drug reaction (ADR), and hospital admission.

Gorbien, Bishop, Beers, Norman, Osterweil and Rubenstein (1992) found that hospitalisation of older people exposed them to significant risk of iatrogenic complications. During hospital admissions older people are prescribed an average of eight medications, and many changes are made to their medication regimen. Further, Wilson, Runciman, Gibberd, Harrison, Newby and Hamilton (1995) in their Quality in Australian Health Care study, identified that 1.6 percent of hospital inpatients of all ages experienced an AME resulting in either disability, death or prolongation of hospital stay. Therefore, since the incidence of AME increases with age, the rate of AME among older patients is likely to be significantly higher than that reported in the aforementioned studies.

Roughead, Gilbert, Primrose and Samson (1998) have estimated that at least 81,000 public hospital admissions in Australia each year result from medication-related problems. This costs Federal and other governments around $350 million annually. Over 50 percent of medication-related hospital admissions involve patients aged over 65 years, indicating that at least 40,000 older Australians are admitted to hospital each year as a result of adverse medication outcomes. Approximately half of these admissions have been judged to be definitely or possibly preventable.

Opportunity Costs

<u>What does $1,015.5M purchase in Public Hospital and Healthcare Services?</u>

1. 394 367 average acute hospital separations (@ national average cost of $2575 / casemix adjusted separation) or 8% of the 97/98 total number of casemix adjusted separations for Australia; OR

2. 8 medium to large teaching hospitals; OR

3. 102 medium sized (203 beds) rural hospitals @ $10m annual recurrent cost; OR

4. 337 Acute psychiatric wards (say 102 beds) @ $ 3m annual recurrent cost; OR

5. 508 medium Community Health Centres (say 33 staff per centre) @ $2m annual recurrent cost; OR

6. 691 (24 Hours a Day) Mental Health Teams (7 staff per shift, @ $ 1.47M per team); OR

7. 508 Residential Drug & Alcohol Detoxification Units (20 bed unit @ $ 2.0M per unit); OR

8. 12 694 Community Nurses fully equipped with cars and equipment (@ $80 000 per nurse); OR

9. 5 078 Staff specialists (@ $ 200 000).

Recommendations

It is recommended that:

1. Best practice prescribing, which is currently focused on the primary care sector via general practitioners, be extended to cover hospital prescribing practices;

2. As part of the development of the electronic health record (EHR), the *electronic medication record initiative* announced in the 2000 Budget, which doctors and pharmacists can adopt voluntarily, be incorporated as a care data item in the contents of any proposed EHR that would become available to doctors, pharmacists and other health professionals as a patient moves across primary care; hospital care; and residential care sectors;

3. Government support be provided in the following ten key areas, which have been identified by the Alcohol and other Drugs Council of Australia for reducing drug-related harm:

   - Reducing the high levels of smoking by young women;
   - Reducing alcohol related violence and disorder;
   - Reducing fatal heroin-related overdoses;
   - Reducing substance misuse by indigenous people;
   - Reducing the misuse of prescription drugs by older people;
   - Increasing funding for prevention and early intervention;
   - Providing support to families;
   - Developing a national workplace alcohol and other drugs policy; and
   - Developing a balanced national drugs research, evaluation and monitoring agenda;

4. In order to be most effective, local, regional, state-wide and national strategies need to be integrated within a common planning framework to consolidate effort, and maximise synergies;

5. There be greater coordination of effort between Commonwealth and State Governments, when planning and developing strategies to address priority issues concerning reduction of the social and economic costs of substance abuse; and

6. Commonwealth drug program funding should *not* be targeted specifically to non-government agencies, as this results in fragmentation of the service system for substance abusers. In many rural areas, local government, public hospitals, or community health centres are the key agencies delivering health services to rural communities. The current practice of funding non-government agencies, disadvantages communities who are not serviced by these agencies, as they are unable to obtain additional resources to meet local need.

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